Name: Vivian Fullagar

Module: GCS1

Cohort S21- RDNA Mental health.

A reflective case scenario was discussed in a group clinical supervision.

Introduction:

This essay will explore patient care while focusing on a patient who was discussed in a group clinical supervision and the experience of the Student Nurse on the general ward. How the group perceived the situation, and the lessons I drew from that discussion and my own practice experience, using the Gibbs' Reflective Cycle (Gibbs,1988) as it is the most popular reflective module used.

Reflection has been viewed as an important approach for professionals who embrace lifelong learning (Jasper, 2013). Professional effectiveness is very crucial in nursing as it requires communicating effectively while working cooperatively with others by sharing skills, knowledge, and experiences (Grant and Goodman 2019). Additionally, Reflection being a standard set out by the Nursing and Midwifery Council (2018) to promote professional accountability and improve practices, has also been a tool that bridges the gap between theories and practices. This is beneficial in identifying any improvements or changes to practices because of what was learned.

Description

During the Group discussion, a scenario was brought forth for discussion that involved a student nurse on her second day of placement, working in a general ward and a 51-year-old female patient on the ward that she cared for that had a diagnosis of Korsakoff syndrome

undergoing monitoring and investigation. Korsakoff syndrome is a memory disorder that results from vitamin B1 deficiency and is associated with alcoholism. (Isenberg-Grzeda et al., 2012). The patient was in isolation and nursed in their own bay due to their presentation and how they were exhibiting. Her bay faced the nursing station for easy access, monitoring, and visibility. This would be the second time the student nurse worked on this ward but the first time she had to look after this patient. The student nurse was not allocated a specific task but was familiar with the ward environment. After the handover was finished, the nurses left to carry out different tasks as was the case every morning after the handover. The patient shouted to be taken to the bathroom despite having been seconds earlier. This behavior continued as the patient would forget that she had been assisted earlier and did not need the bathroom that soon. Being the only nurse visible, the student nurse continued to take the patient to the bathroom as requested and most times it would turn out to be a false alarm confirmed by the patent herself. The student nurse at this point was starting to feel frustrated and exhausted by the situation, meanwhile, the patient was becoming increasingly agitated, and verbally hostile toward the student nurse. It was stated that the student nurse worked a twelve-hour shift attending to this patient with no support from her colleagues.

Feelings

As a group, we were alarmed that the student nurse was left on a twelve-hour shift to attend to this patient with no support from other colleagues. Yet Professional Standards of Practice and Behavior for Nurses and Midwives (NMC, 2015)11.2, clearly states that "making sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care". It was highlighted during the group responses that the student did not feel confident to express how frustrated she felt about the situation despite being given the opportunity at the end of her shift when she was asked how her shift went. The student nurse

reported that she felt anxious about being honest for the fear of being perceived as an incompetent (Melincavage, S.M., 2011). She learned that next time she finds herself in a similar situation, she will speak up and ask for support and guidance from her seniors on the ward despite the busy environment. Another point that was highlighted during the group discussion was the working culture in the ward where it seemed that students on the ward are overlooked by the experienced staff and perceived as an additional burden to other staff. This can be quite dangerous as it prevents students from seeking support and therefore limits learning opportunities. According to the (Ministry of Education and Research, 2004), as students, we should be able to demonstrate the ability to observe, reflect, analyse and systematise from both theoretical and clinical perspectives by participating in relevant nursing care scenarios that integrate theory and practice. What I have observed and learned throughout my own work experience is that mental health heavily relies on great teamwork between practitioners and the lack of this can greatly affect the quality of care to the patients and how things can go wrong when people don't speak up. According to (Nacioglu, 2016), speaking up is one of the critical behaviors for patient safety, therefore being aware of factors that influence and enable speaking up behavior improves the quality and safety of healthcare. I did not feel that the student nurse had been given a thorough handover of the patient before starting her shift as this would have informed her understanding of the patient she was looking after. Handover remains a crucial ritual in nursing that contributes to the improvement of care for the patients. Poh et al (2013). I felt that the student nurse lacked experience and had little knowledge of how Korsakoff syndrome manifests as an illness and this also contributed to her frustration in dealing with the patient and her behavior.

Evaluation

In hindsight, the student nurse's experience highlighted both negative and positive elements that informed me and the group about what good practice and bad practice can look like. As Nurses, we are expected to operate within the four themes of the Nursing and Midwifery Council namely, prioritizing people, practicing effectively, preserving safety and Promote professionalism. There was a clear demonstration of prioritizing people when the student nurse made a choice to remain and look after the patient and this was a clear example of good practice (Weeks, K., et al,. 2017). There was a concern when the patient kept requesting to be taken to the bathroom and despite this repeated behavior, the student nurse calmly adhered to the patient's request which is a good showcase of effective practice. Regarding preserving safety while promoting professionalism, the student nurse maintain interaction with the patient as a tactic to keep the patient distracted while deescalating her obvious underlined frustration.

Analysis

According to (Waugh et al.,2014), people are experts in their own experiences. In the case of the student nurse in the case scenario above, she surrendered to her own fear of not speaking up at what she felt was a unfair situation to be left in. She however turned the situation round to work for her where she built a therapeutic relationship with the patient, working alongside her for contemporary recovery and focused practice. The underlying premise of the transference hypothesis is that experiences and memories from the past inform present behavior (Regan, P., 2012.), this will be an isolated incident as the student nurses learn how best to navigate professionally when in a new team and still be able to learn. Initially the team on the general ward thought that the student would slow them down hence whys she was ignored and left to work on her own with a patient, however when the student gives feedback about how she was treated, They will not receive it gladly as it will highlight their weaknesses and learning curves. During the group supervision I found two main elements that help me understand what

the main issue was Team roles and predictions of new students on the ward environment. With team role, the person in charge would have paired the student nurse so that she identifies her strengths and weakness while shadowing a permanent staff. Effective teamwork and work delegation come from using people's different strengths, in this case, were not utilized. While predicting the outcome of the kind of shift you want to have as a nurse in charge, Nurses have to be professional advocates with consideration of ethical decision-making and communicate this clearly while maintaining service users rights and best interests (Buka 2015b; Mahilin 2010).

Conclusion

I have learned the importance of handover when you first arrive on a ward environment. This is when you have a chance to listen and ask questions that pain a patient or patients that you have allocated to or have a good understanding of the basic information about patients and how they might exhibit. I learned that sometimes we might need to challenge conclusions made in during group discussions to ensure that we are not agreeing just because of group thinking.

During the case study that involved the student's experience, I learned the importance of putting your point across to avoid stressful situations that only amount to frustration and not positive attributes

References

Buka,P.(2015) *Patient's rights Laws and Ethics for Nurses. 2nd edn.* London:CRC Press.

Grant, A. and Goodman, B. (2019a) *Communication and Interpersonal Skills in Nursing.* 4th edn. London. Sage.

Isenberg-Grzeda, E., Kutner, H.E. and Nicolson, S.E. (2012) 'Wernicke-Korsakoff-Syndrome: Under-Recognized and Under-Treated', *Psychosomatics*, 53(6), pp. 507–516. doi:10.1016/j.psym.2012.04.008.

Jasper, (2013) Beginning Reflection 2nd edition. Andover: Cengage.

Manley, K. 2008 “The way things are done around here”-Developing a culture of effectiveness: a pre-requisite to individual and team effectiveness in critical care’, *Australian critical care : official journal of the Confederation of Australian Critical Care Nurses*, 21(2), pp. 83–5. doi:10.1016/j.aucc.2008.02.002.

Melincavage, S.M., 2011. Student nurses' experiences of anxiety in the clinical setting. Nurse education today, 31(8), pp.785-789.

Nacioglu, A., 2016. As a critical behavior to improve quality and patient safety in health care: speaking up!. Safety in Health, 2(1), pp.1-25.

Nursing and Midwifery Council (NMC 2015)

Regan, P., 2012. Reflective insights on group clinical supervision; understanding transference in the nursing context. *Reflective Practice*, *13*(5), pp.679-691.

studies, *51*(8), pp.1123-1134.

Van Bogaert, P., Timmermans, O., Weeks, S.M., van Heusden, D., Wouters, K. and Franck, E., 2014. Nursing unit teams matter: Impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse reported job outcomes, and quality of care, and patient adverse events—A cross-sectional survey. *International journal of nursing*

Waugh, A. *et al.* (2014) ‘Supporting the development of interpersonal skills in nursing, in an undergraduate mental health curriculum: Reaching the parts other strategies do not reach through action learning’, *Nurse Education Today*, 34(9), pp. 1232–1237. doi:10.1016/j.nedt.2013.10.002.

Weeks, K., Coben, D., Lum, G. and Pontin, D., 2017. Developing nursing competence: Future proofing nurses for the changing practice requirements of 21st century healthcare. *Nurse Education in Practice*.